CETCLEVELAND®

Beyond Treatment As Usual (TAU)
For Major Mental Illness
February 12, 2015

Albert Einstein famously said, "Insanity is doing the same thing over and over again and expecting different results." It's been 60 years since antipsychotic medications came into widespread use and 20 years since the introduction of atypical antipsychotics. But far too many people remain stalled in their recovery from major mental illness. Most mental health agencies practice "Treatment As Usual" or TAU. They advise their clients: "Take your meds, stay out of trouble and maybe you'll get better." But even if TAU includes more than meds (e.g., Assertive Community Treatment [ACT], supportive employment, housing programs, community support, etc.), there needs to be effective ways to address cognitive deficits and negative symptoms. What we have now is incomplete recovery due to incomplete treatment; thus, we are doing maintenance management, not active treatment.

"Whatever part of the problem you are trying to solve, make sure you're not just attacking the noisy part of the problem that happens to capture your attention." writes Freakonomics authors Levitt & Dubner (1). "Before spending all of your time and resources, it's incredibly important to properly define—or better yet, redefine the problem." And "Only by redefining the problem was he able to discover a new set of solutions."

Are we too focused on the noisy part of mental illness: the positive symptoms of hallucinations and delusions which usually respond to medications? What of the more insidious cognitive deficits and negative symptoms of impaired memory, processing speed and lack of social cognition that prevent more complete recovery?

The problem needs to be redefined as "Incomplete Recovery" and our focus shifted to impaired cognition and social functioning in addition to the noisier acute psychotic symptoms. Such broader based thinking leads to new discoveries, innovative solutions and better treatment outcomes for those experiencing major mental illnesses.

The sooner and more aggressively we intervene, as is the case with every chronic health condition, the more likely we are to get to recovery with the lowest possible investment of resources. By waiting until stage four of the illness, we make recovery less likely and consign ourselves to the kind of maintenance management strategies that may prolong life, but typically do not help an individual recover fully.

In 2010, the estimated 30-day hospital readmission rate for clients with schizophrenia was 22.3%. Schizophrenia has among the highest 30-day readmission rates for the most frequently treated conditions in U.S. hospitals. Other conditions with high readmission rates include congestive heart failure, at 24.7% and acute and unspecified renal failure, at 21.7%. (2) Physical health organizations are investing millions to reduce readmissions

but mental health systems remain at bare-bones. They do the basic job—trying to prevent rehospitalization- but do not significantly alter the course of the illnesses.

The problem of Incomplete Recovery may be that we accept TAU, or maintenance management, without thinking about what might be added to bring better results for more people. We can, and should add to medication and support, a rehabilitation component focusing on remediating disabilities while building the client's strengths. Cognitive remediation in general, and Cognitive Enhancement Therapy (CET) in particular, have succeeded in shifting the treatment paradigm from maintenance to truly active treatment. (3)

Active treatment can achieve quicker, more complete and lasting recovery. We need to challenge clients and staff to work on cognitive deficits instead of accepting them as the norm. This shifts the view from seeing the client as incompetent, to seeing him or her as someone who can recover, through educating and coaching them in a rehabilitative process. We have been searching too long for a magic pill to solve our clients' problems rather than actively helping them address their weaknesses and challenges, and build on their strengths to help them more fully recover.

To put this into context: If you're teaching someone how to drive and you work on city driving in the daytime but not on highway driving at night, they won't be a competent driver. If you teach clients to take medication consistently, but don't address deficits such as impaired social cognition, how will they become a more competent individual?

CET is a Substance Abuse and Mental Health Services Administration (SAMHSA) recognized Evidence Based Practice (EBP) that helps people with schizophrenia and other cognitive disabilities improve processing speed, cognition (attention, memory, and problem solving), and social cognition (the awareness of, and skill at, social interaction), all of which improve interpersonal effectiveness.

As a rehabilitation treatment for interpersonal effectiveness, CET does far more than just teach social skills. The CET curriculum, group interaction and mentoring, foster growth in interpersonal effectiveness which transcends mere skillful interactions while also promoting better neurological functioning. The socially skilled person may know the right thing to do or say in some situations. The person who is interpersonally effective can plan strategically to develop relationships and partnerships. Interpersonal effectiveness is the essential ingredient in building and maintaining meaningful personal and vocational relationships, i.e. getting and keeping jobs.

Not all individuals in recovery from major mental illnesses need a multi-faceted, rehabilitation oriented program given over 48 once-a-week sessions such as CET. But for many individuals, relearning how society and the workplace operate while addressing significant cognitive deficits, an in-depth, curriculum-driven approach is helpful. CET is provided in a largely group-based format that promotes social interaction and teamwork. Our clients did not become ill overnight so deeper recovery also takes time.

The words of a new CET Coach (therapist), a psychiatric nurse of 30 years says it all, "In hindsight, we underestimated our clients. They were on the best medication and stable. We thought they had improved as far as they could. What else was there? … Now, we understand from CET, that their potential is not gone—every bit is open ended. … Yes it's slow. But every week we saw little changes. That has been exciting. It's a contagious energy to witness. … Every participant has improved. I have so much more hope now than ever before."

CET has been validated as an EBP in research funded by the National Institutes of Mental Health (3). It has demonstrated increase employment outcomes for CET graduates (4) and is remarkably durable (3).

CETCLEVELAND® is a form of CET that Sam Flesher, Ph.D. (the co-developer of CET along with Professor Gerard Hogarty at the University of Pittsburgh) designed and implemented as a community-based intervention at PLAN of NE Ohio, Inc. Since 2001, over 2,400 adults have completed CETCLEVELAND® groups at 40 sites in 12 states (as of July 2016), with another 400-plus adults currently attending CETCLEVELAND® groups. At 10 of these sites, training in the CETCLEVELAND® model is in progress (5).

Nationally CETCLEVELAND® has an average of 80 to 85% attendance and graduation rates with most individuals retaining their improved social and vocational functioning at up to 10 plus years. It also appears to facilitate a very significant reduction in psychiatric bed day usage (70 to 90% during the CET treatment year and for at least thirty-six months post graduation) for CET graduates.

Recovery is not only possible; we at the Center for Cognition and Recovery believe that is the norm. To move beyond Incomplete Recovery due to Incomplete Treatment, our clients need more than TAU and maintenance management, they need active treatment. They need a holistic approach with a strong theoretical base and practice that has demonstrated its effectiveness in a wide range of treatment sites. They need cognitive remediation in general and Cognitive Enhancement Therapy or CET in particular.

Sources

(1) Thinking Like a Freak page 51, page 62
(2) Anne Elixhauser, Ph.D. and Claudia Steiner, M.D., M.P.H., Readmissions to U.S. Hospitals by Diagnosis, 2010 STATISTICAL BRIEF #153, HEALTHCARE COST AND UTILIZATION PROJECT, Agency for Healthcare Research and Quality
(3) Hogarty, G. E.; Flesher, S.; Ulrich, R.; Carter, M.; Greenwald, D.; & Pogue-Geile, M. Cognitive enhancement therapy for schizophrenia, effects of a 2-year randomized trial on cognition and behavior. Archives of General Psychiatry, 61, 866-876. Additional results from an analysis of three years of data from this

study were published in 2006, Durability and Mechanism of Effects of Cognitive Enhancement Therapy, Psychiatric Services, 57, December, p1751-1757.

(4) Eack S, Hogarty G, Greenwald D, Hogarty S, Keshavan M. (2011). Effects of cognitive enhancement therapy on employment outcomes in early Schizophrenia: results from a 2- year randomized trial. Research on Social Work Practice, 21(1), pp. 32-42.

(5) Flesher, S. Shumaker, S. (Eds.). (2004-2009-2014). CETCLEVELAND® Manual, Beachwood, OH.

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